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Vol. CVI NOVEMBER, 1912 Number II

NASHVILLE JOURNAL

OF

MEDICINE AND SURGERY

CHARLES S. BRIGGS, A. M., M. D., Editor and Proprietor
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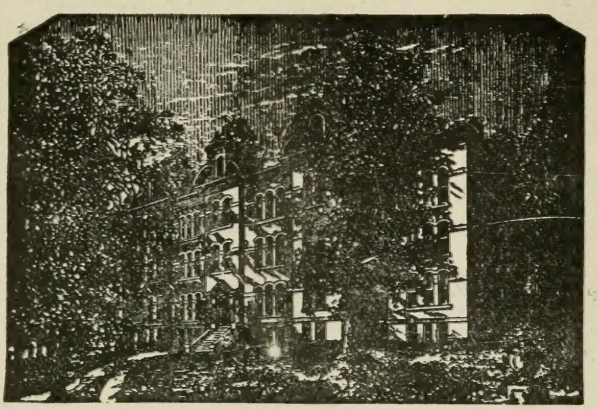

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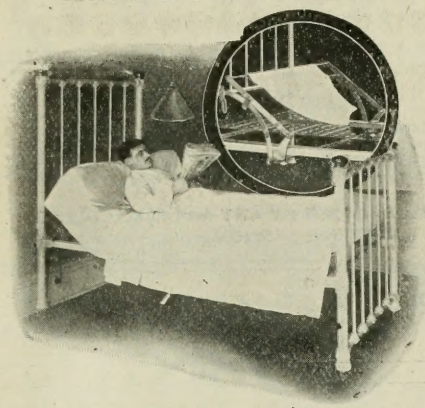

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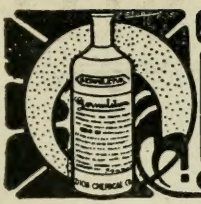

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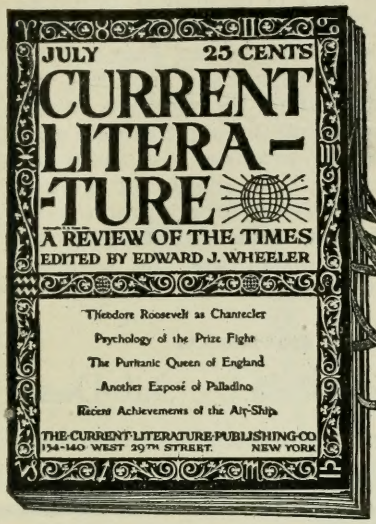
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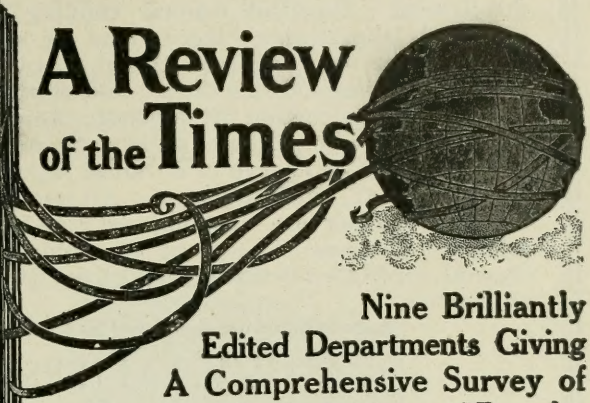

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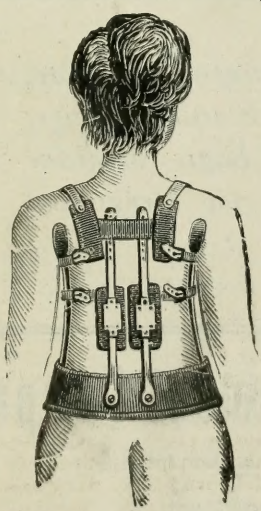

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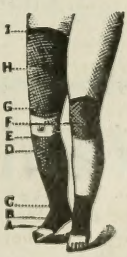

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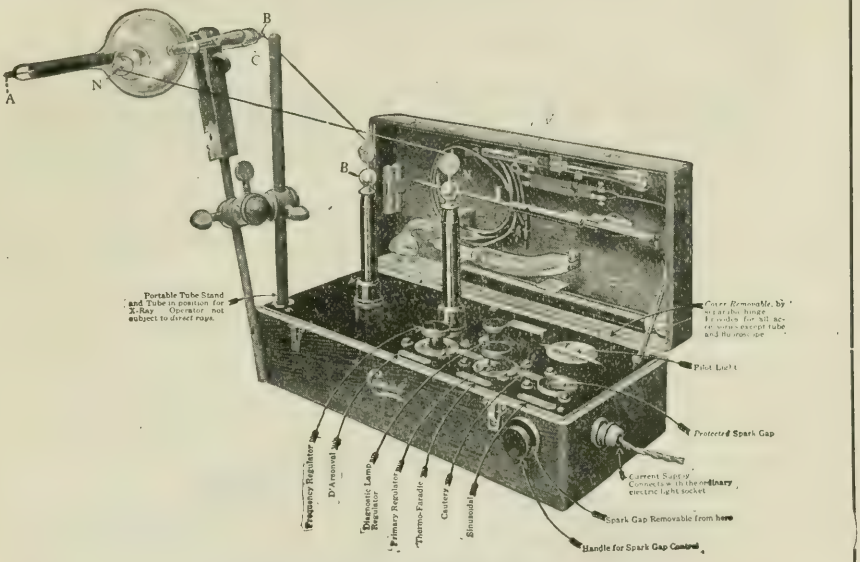

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NASHVILLE JOURNAL
—OF—
MEDICINE AND SURGERY

CHARLES S. BRIGGS, A. M., M. D., Editor

VOL. CVI. NOVEMBER, 1912. No. 11.

Original Communications

INSANITY OF INEBRIETY.

By T. D. CROTHERS, M.D., Superintendent Lodge Hospital, Hartford, Connecticut.

To call all persons who drink spirits to excess "alcoholics" is misleading. This term gives the impression that the condition present is a specific toxic state due to alcohol alone.

A study clinically often indicates that the use of spirits follows head injuries, infections fevers, shocks, sunstrokes or some distinct drain and condition of profound exhaustion; therefore it is only a symptom, which very likely increases the original condition.

The term inebriety more accurately describes some pathological condition for which alcohol is the most grateful narcotic. Here spirits are simply a symptom of some previous degeneration and diseased condition.

Clinical studies show that a very large percentage of drink and drug neurotics have had a previous history of degeneration and disease before the spirits were taken. Historically, the fact of disease was recognized long before insanity was thought to be other than spiritual madness.

The insanity of drinking men is a very old subject. The theory still exists that the early use of spirits is a moral condition, and so-called vice, and only after spirits have been used to great excess is there any possibility of disease.

A scientific study indicates the error of this theory, and that there is a distinct insanity in the use of alcohol which should be recognized. The periodic drinker, who after distinct periods of abstinence uses spirits to great excess, is undoubtedly a maniac, suffering from circular insanity.

The sudden onset and its convulsive control resembles epilepsy, and in many of the cases the relation is very close. Often the periodic drinker will have a distinct prodroma marked by insomnia, headache and great irritability and other very distinct symptoms of mental and physical change.

He does not recognize these are precursors of a drink storm, and appears to have no consciousness that they will culminate in an impulse to drink that is uncontrollable. Many persons of this class from experience recognize that these psychopathic symptoms will end in alcoholic excess.

They show a reasoning mania in provision for these attacks, arranging their business, regulating their surroundings, even when perfectly temperate and free from any impulse, knowing that the drink storm is sure to come.

It is noted that many persons are greatly exalted, up to the point of delirium in many ways at this period, or depressed, and become melancholic, then suddenly the impulse breaks out and all these symptoms pass away.

The duration of the free interval is often very exact as to time, and this resembles circular insanity. The patient's health continues good, and there are no symptoms of mental disturbance up to within a few hours of the insane impulse to drink.

The duration of the drink storm is also remarkable as to length. In many cases both the onset and duration of the drinking period can be predicted with certainty.

The startling changes of character and conduct within an hour are additional evidence of the insanity. Thus a previously moral, exemplary man, suddenly, after a few drinks of spirits, becomes a criminal, an imbecile, immoral and treacherous to the last degree. His criminality lacks continuity, and is of the impulsive, delusional character. On the subsidence of the drink craze these

peculiar symptoms disappear and he becomes a normal man in character and conduct.

The use of spirits develops delusions, hallucinations and melancholia, which subside when the paroxysm is over as quickly as it begun. Often the history of the periodic drinker indicates a marked heredity and a defective brain and nerve organization, which is increased by strains of business, predisposing the nerve energies to convulsive activity.

Another phase of insanity equally prominent and of most fascinating interest is that seen in persons who use spirits regularly, either in so-called moderation or to excess. The cumulative action of alcohol on the physical and psychic centers of the brain has not been studied very clearly.

Clinically, the steady user of spirits develops very marked symptoms of insanity. There is an exhalted ego and delusions of strength in power, which, whenever practically tested, are found to be wanting. Experience and failures make no impression, but only increase a form of paretic exaltation and delusional confidence in his ability and capacity to reason and act.

Later, delusions of suspicion and want of confidence in his nearest relatives and friends, particularly the infidelity of his wife and the treachery of his children appear. His memory fails. His reasoning on matters outside of his everyday vocation is childish and simple. He becomes markedly credulous or skeptical on matters that previously did not attract his attention.

His value in positions of trust and responsibility is irregular and uncertain. He works fitfully, and when occupying a responsible position is either discharged or placed in a position where his judgments can be corrected.

Whatever opinion may be entertained by his friends or associates in the business world, he is considered irresponsible, degenerate and uncertain.

Another symptom of insanity comes into prominence in some instances. This is marked by a great failure to recognize the consciousness of right and wrong, duty and responsibility. His mentality has changed. There is feebleness, concealed delusions

and perversions of judgment manifested in conduct, varying widely from its former condition.

The sensory activity show palsy and great diminution of former acuteness. There are marked organic changes which are shown in the failure of nutrition, irregularity of the heart's action, loss of endurance and general vitality.

The modern instruments of precision can measure these abnormal conditions with great certainty. The feebleness of memory, the slowness of the mental operation, the faults of judgment and sensory discriminations and mental feebleness of reasoning with tensioned arteries and other conditions can now be mapped out with great certainty, yet many persons classed as periodic or moderate drinkers are not recognized as coming under the head of insanity.

It is literally an insanity of the paretic type with both exaltation and imbecility. At certain stages these symptoms are so marked that they can not be questioned. There is a beginning to this which escapes the attention of most observers. There is anæsthesia and diminished functions and organic shadows creeping over the mentality. The fine shadows, the uncertainties and doubts which attend all human transactions, escape the notice of a drinking man, and he imagines they do not exist. The more alcohol he uses the more positive this appears.

His condition is one of increasing anæsthesia, manifest in the rude grasp of the hand, loud voice, and exaggerations of manner as if to assure himself of the reality of his senses. He is constantly becoming more and more incapable of receiving accurate knowledge of persons or events, and the impressions he gets are imperfect, incoördinated and not accurately understood.

All these are simply the early stages of insanity. For a time he may act and reason along accustomed lines with automatic sanity, but place him in new conditions, and his mental defect and real condition will show itself.

This form of insanity is very pronounced in America, and is based on the continuous strain and drain incident to the changing conditions of the country. It is neurasthenia, fatigue and brain exhaustion. Then spirits to cover up this condition, with more

pronounced brain and nerve debility. Then follows irregular life, irregular conduct, strange reasoning, delusional and delusive activities, acute organic inflammation and death.

The last disease is supposed to be the cause of death. In reality the man was alcoholically insane, beginning from exhaustion, or perhaps with spirits, and his conduct was that of a psychopath and mental defective.

A certain small number of cases of this kind commit crime and die in prison. A large number go on to extreme stages, become dements and paretics and end their days in an insane asylum. A still larger number die from acute organic disease which comes on unexpectedly and terminates rapidly.

The public recognizes that these persons are classed among the border liners, or persons who lived in the penumbra region of insanity. The fact that they do not go on to extreme stages gives the impression that they can not be called insane according to the strict meaning of the word, and yet this is wrong.

They constitute a class of as thoroughly insane persons in many particulars as the inmates of insane hospitals. There can be no doubt that the anæsthetic effect of alcohol gives certain form and direction to this condition, which is not yet recognized in medical circles.

Medicolegally, it is a question of the highest practical interest, and the effort to mark out boundary lines between sanity and insanity results in great confusion and positive errors. Thousands of these insane people are punished by death and imprisonment for life, simply through ignorance to recognize the real conditions.

There is no subject more intensely practical for the medical man, and no field calling for exact grouping of the facts and the laws which govern their rise and progress, than this: the insanity of inebriety.

SYPHILIS IN GYNECOLOGY.

By E. S. McKee, M.D., Cincinnati; Gynecologist to the Cincinnati Polyclinic.

The initial lesion of syphilis is found most frequently on the vulva. About thirty per cent occurring on the labia majora. Next most frequent is the introitus near the meatus and nymphæ; then the fourchette, and lastly, the clitoris. The vagina is rarely the site of the initial lesion. The posterior lip of the cervix is not infrequently the site of the initial chancre. This is sufficiently frequent and dangerous to the examining physician to make it wise for him to wear rubber gloves; indeed, a gynecologist more than any other specialist is liable to the professional contraction of syphilis. This is due to the hidden locations of the chancres. Statistics shows that 5 per cent of cases of syphilis are of nonvenereal origin. Syphilitic infection may be carried by the semen is admitted, hence we must allow the rare possibility of a chancre in the body of the uterus or even the Fallopian tubes.

The labia majora, one or both, may be the seat of gummatous changes late in syphilis. This is generally an indolent affection and often confused with elephantiasis of the labium. Occasionally the ostium vaginæ is converted into a vast gummatous mass, including the vestibulum and urethra. Gummatous ovaries are often changed into a cicatricial mass rendering the patient sterile. It is often necessary to differentiate chancre of the vulva from ulcer, chancroid ulcer, cancer, tuberculous ulcer and lupus. The finding of the spirocheta pallida makes the diagnosis absolute. This is also the positive means of diagnosing cancer of the cervix. Syphilitic ulcers are often mistaken for cancer. The history of syphilis, the prompt response to acute syphilitic treatment and the microscopic examination, will serve to render the diagnosis plain. Condylomata of the vulva are auto-inoculate and spread onto the mons.

Syphilides, especially mucous patches, are frequently found upon the vulva and down over the perineum and anus, and even

the thighs. They sometimes become confluent and form large cauliflower masses of excrescences like carcinoma. They are apt to bleed surprisingly.

Syphilitic endometritis is not very pronounced and not very well understood, especially in the non-impregnated uterus. Syphilis attacks the pregnant uterus in an agggressive manner, producing changes in the placenta and decidua which are the frequent cause of abortions and miscarriages. Endometritis is sometimes due to an irruption of syphilitic germs upon the endometrium. Bouebard and Lepine report a case of syphilitic salpingitis.

Investigations of an exhaustive nature shows that 80 per cent of women suffering from syphilis are loose women. The other 20 per cent are respectable women. These statistics are gathered by Fournier and agreed to by Ricord. Statistics also show that 5 per cent of cases of syphilis are of non-venereal origin. This should be remembered by those who think syphilis a monopoly of debauchery. For the benefit of these 20 per cent of innocent women, if not for the others, syphilis should be controlled and prevented. A married, virtuous woman may be affected by a husband suffering from ante or post nuptial syphilis or through a fetus.

Wetnursing of syphilitic children by healthy nurses or healthy children by syphilitic nurses, is a great question, and calls for much bravery on the part of the physician. Whole families have been infected in this manner. It is better that a syphilitic child should die than that a healthy wet nurse should be infected.

Pregnancy may occur in a healthy mother from a syphilitic husband one or more times without infecting the mother, but is is highly improbable. In some cases of abortion, due to syphilis in the father, the mother, even though she shows no symptoms of syphilis, will give the Wasserman reaction.

Proceedings of Societies

THE ACADEMY OF MEDICINE, CINCINNATI, O.

Selection on Specialties.

Paper—"The Necessity for Public Prophylaxis Against Venereal Disease"—Illustrated by lantern slides.—Dr. August Ravogli.

An invitation has been extended to a number of municipal officials to whom discussion will be open.

Notes.

The opening session of the Academy of Medicine was a very interesting and enthusiastic meeting. The attendance was good and the case reports would do honor to any medical society.

Dr. J. A. Thompson presented the following motion: "Moved that the Committee on Public Lectures in collaboration with the Publicity Committee of the Ohio State Medical Association be directed to immediately arrange for public meetings in as many localities as possible in Hamilton County. Besides giving instruction in the preservation of health, the speakers at these meetings shall be requested to discuss the purpose of the medical practice laws and the necessity for their preservation." Seconded and carried.

Every practitioner in the county should read the recent editorials in The Lancet-Clinic of September 14, 21 and 28, by Dr. J. A. Thompson, and they will then have a better idea as to the scope, purpose and necessity for the active campaign along the lines of Dr. Thompson's motion.

Dr. Joseph Ransohoff presented a very rare and interesting condition in a four-months-old baby—a median harelip. Dr. Ransohoff said it was the first he had ever seen among probably three or four hundred cases that he had observed during his practice.

Dr. Rufus B. Hall reported (full report in Lancet-Clinic): (1) Case of gall-stone obstruction of the common duct; opera-

tion; recovery. (2) Multinodular uterine fibroid, with specimen. Operation presented unusual difficulties owing to the nodules filling the pelvis, making delivery difficult.

Dr. Joseph Ransohoff read the report of a gunshot wound of the abdomen necessitating multiple resection of the intestine due to extensive injury of the bowel. The bullet was of large calibre and on going through the clothing it carried with it a portion of a large safety pin, which was responsible for such extensive laceration of the gut as to necessitate resection. The man's convalescence has been stormy, but he is a trifle improved on this the fourth day ofter operation (city hospital).

Dr. Charles E. Caldwell then reported somewhat in detail a series of gunshot and stab wounds of the abdomen. Complete report will be published in The Lancet-Clinic later.

Dr. J. Ambrose Johnston reported a case and presented the specimen of panhysterectomy for carcinoma of the body of the uterus (one year's standing from history). Dr. Johnson clearly enunciated the dictum that cancer of the uterine body offers a better prognosis than cancer of the uterine cervix, and mentioned previous experiences and statistics to bear out his point. Dr. Johnston also presented the specimen of uterus (vaginal hysterectomy) removed for cancer of the cervix. White woman, aged thirty-six. Only symptom hemorrhage for one month. This he said was as early as we could hope to get these cases, yet the prognosis was much less favorable than in the previous case. Discussed by Drs. Magnus A. Tate and Rufus B. Hall. Both agreed as to the point of prognosis made by Dr. Johnston.

Dr. C. S. Rockhill reported a number of cases of tuberculosis, bringing out the clinical side of the cases and then comparing the microscopical and X-ray findings in order to corroborate or disprove the clinical diagnosis. Careful analysis was shown to be very necessary in a large number of these early chest cases. The differentiation of tuberculosis and syphilis was shown to be very difficult in one case, until he tried salvarsan, which completely cleared up the picture. No special mention was made of the value of the Wassermann test as a diagnostic measure. Dr. H. K. Dunham demonstrated a number of X-ray chest pictures taken

of the cases reported by Dr. Rockhill. Most interesting of all he showed a chest picture taken of an infant that was clear and showed excellent detail. It was taken in one-eighteenth of a second's time exposure. This brings us to where we can make the X-ray aid us in the chest diagnosis in children even though they kick and cry.

Dr. W. D. Hines reported a case of compound fracture of the forearm in a man aged thirty, which was reduced and put in plaster. X-ray taken and fracture treated by open method of plating. Good apposition was obtained and patient kept at rest for three weeks. A small pustule developed which healed. Later the plate was removed but no union had taken place. The case was then lost sight of. Dr. Haines believes that plates should be used in certain cases, but that they fail at times. Full report of this case will appear in an early issue of the official organ. Discussed by Dr. Caldwell, who said he did not think the bone plates, *per se,* were a cause of non-union, but that a rather large callus was formed where a plate was used. He though interposition of soft structures and disturbance of nerve and blood supply was a cause. Syphilis is a questionable cause. Dr. Carother's took the ground that bone plating was rather more frequent now than it would be in the future, and that a good plaster technique would serve in most cases, but plating has a definite place in surgery. Dr. Ricketts uses mercury in most cases of fracture and believes that it has a definite value in preventing non-union. Foreign bodies are also a probable cause of non-union.

Written case reports that are to be published will be only briefly abstracted by The Bulletin.—C. T. Souther, Editor.

Monday, October 14, 1912.

Surgical Section.

Paper—"The Comparative Value of the Medical and Surgical Treatment of Puerperal Eclampsia."—Dr. E. G. Kinke.

Paper—"A Comparative Study of the Appendices and Cecæ of Vertebrates, with an Addition of Small Birds' Appendices to the Literature."—Dr. D. D. DeNeen.

NOTES.

In the absence of President Porter, Dr. J. Ambrose Johnston acted as presiding officer.

The following names were presented for application to membership and referred to the Board of Censors: Drs. E. R. Twachtman, W. C. Clark, C. Walter Manss, Chas. A. Hoefling, J. D. Spellman.

Dr. Otto P. Geier called attention to the Municipal Exhibit now at the old St. Nicholas Hotel building, and emphasized the importance of every physician making a personal call to see the exhibit. He stated that it was well worth five hours of any man's time. It is a bit of political economy education that it would take months of careful study to acquire from any other source. It should be considered a privilege to have a chance to get so much, in so condensed a form, of the inside business working of our municipality. Dr. J. A. Johnson emphasized Dr. Geier's statements.

Dr. B. M. Ricketts presented a patient, man, thirty years old, who, while doing electrical work on power-house had his head come in contact with a feed wire which became grounded. The feed wire was carrying 33,000 volts of current. Patient fell thirty-three feet to ground and fractured arm and shoulder and burned the external soft parts of top of head and external table of skull. His feet were burned and the nails in shoe heel melted into iron plate on which he was standing. External table of skull was finally thrown off as sequestrum, and is healing over after fifteen months. Man is otherwise well.

Dr. Ben F. Eckman presented a piece of omentum removed intra-abdominally from its incarcerated position in the ruptured uterus. From the history of the case it had probably been in this unusual location nine months. Dr. Eckman said it was the second case of the kind he had seen. The other case when reported to the Academy had caused some criticism. Dr. Gillespie asked if there had been a history of previous recent abortion? Answer, no; but patient gave birth to a child nine months previous. Dr. R. B. Hall asked if patient had menstruated since confinement. Answer, no.

Dr. Ravogli's paper on "The Necessity of Public Prophylaxis of Venereal Diseases," contained many suggestions as to possible methods of dealing with this most important sociological problem. He takes the ground that segregation and examination by the health department is the best method. Men who are thoroughly competent should do the work of examining at frequent intervals, and be paid a salary sufficient that their whole time can be devoted to the work. Infected women should be sent to the hospital, and detained until they can no longer communicate the disease by sexual congress.

Dr. Edwin Shields took the ground, in discussion, that there were so many objections to the method advised by Dr. Ravogli that it was a bad thing. Why legislate against women and let the men go free? He contended that the work of examining these women as done years ago had been abused, and the chance for graft was too great with the method advised. He said members of the profession had not been fair or truthful in their reports on this work.

Dr. Gillespie believed it could be done, and had a better opinion of the profession than to think they would stoop to any such things as the previous speaker intimated.

Dr. Dunham said it could not be done here as abroad on account of this being an Anglo-Saxon race.

Dr. Heidingsfeld discussed the problem and spoke of methods in vogue in Vienna and Berlin.

Dr. Louis A. Molony spoke of the plan of having the redlight district removed to a distance from the heart of the city, and called attention to the methods in vogue in Japan.

Dr. A. W. Nelson also discussed the question of the real value of any control method, and said it was very hard to either control or estimate its value, but the protection from all contagious disease certainly was right.

Dr. Stanley Zinke said that what was necessary were laws to back up the control and then not only the women but the men should all be examined before they are allowed to cohabit with public women.

Dr. J. H. Landis discussed the problem from the standpaoint of the health department and said it was very much of a question whether the method being tried in Minneapolis and Chicago were good. Cleaning out the public brothel and forcing the women into flats and respectable parts of town is a questionable procedure. He did not see why all laws pertaining to contagious disease could not be enforced against syphilis and gonorrhea. The health department had frequently discussed the problem, but had no money to carry on any control.

Dr. Walter Griess detailed the methods in vogue in German cities and in France, and presented the literature used by the department (police) to control and record the prostitute.

Monday, October 21, 1912.

MEDICAL SECTION.

Paper—"A Comparative Study of the Appendices and Cecæ of Vertebrates, with an Addition of Small Birds' Appendices to the Literature."—Dr. D. D. DeNeen.

(This paper was carried forward from the meeting of October 14 for this meeting by order of the Academy.)

Paper—"A Definition of Nervous Dyspepsia."—Dr. Henry Wald Bettmann.

NOTES.

Those who have not paid dues please remit to the treasurer, Dr. A. G. Drury, 836 Lincoln Avenue.

Dr. Oscar Behrman, 2615 Reading Road, has applied for membership.

Dr. Carothers' motion that a committee be appointed by the Chair to act as a reception committee to our distinguished guest, Mr. W. Arbuthnot Lane, of London, England, and to manage the First Councilor District Meeting, to be held in November, was seconded and carried. Dr. Porter appointed on that committee Drs. Carothers, J. Edw. Pirrung, John D. Miller, C. T. Souther and Frank Lamb.

Dr. J. W. Murphy presented a case of rhinophyma in a patient, and spoke of the method to be used in treatment. Patient

was also suffering from ectropion. Dr. Wyler had operated one eye and the other would be operated later.

Dr. Robert Sattler presented a patient with large angio-fibroma of left temporal region and another angioma on eye and side of nose. The external carotid had been tied as a preliminary measure to other operative interference. The ligating of the external carotid had caused so much improvement that further interference would probably not be necessary.

Dr. B. M. Ricketts reported five cases (to be published in The Lancet-Clinic later), as follows:

1. Resection of elbow joint following injury.

2. Specimen of large cystic goitre (not exophthalmic).

3. Case of large cystic goitre treated by aspiration.

4. Case of osteomyelitis in girl eight years where the hip was primarily involved and later the tibia and fibula, necessitating amputation below the knee.

5. Case where a patient fell 152 feet and recovered with a dislocated kidney, kinking of ureter and necrotic spot in kidney necessitating nephrectomy; death from shock.

Dr. E. G. Zinke presented the regular paper of the evening: "Comparative Value of Medical and Surgical Treatment of Eclampsia." The paper covered the whole field in a very careful, painstaking and scientific manner. Much data and statistics were presented, including twenty-nine cases by the author, showing the relative value of medical and surgical treatment.

Dr. B. M. Ricketts, in discussion, brought out the value of rapid work when operation was resorted to, and spoke of the inability to arrive at a reliable conclusion based on statistics, for the reason that probably many medically treated cases resulting fatally were never reported, while surgeons were more apt to record results. The uterus can be emptied very rapidly under local anæsthesia, thereby avoiding the risk of yellow atrophy that may follow a general anæsthetic.

Dr. Wm. Gillespie took the ground that surgery was not the treatment for eclampsia except in rare cases, as many cases developed after the uterus had been emptied. A study of the litera-

ture for the last sixty years would indicate that violence was not necessary. Mortality rises in proportion to the activity of the interference. Chloral, up to sixty grains per rectum and veratrum in full doses of ninety minims, was at times necessary to control a case. Convulsions precipitate labor. Treat convulsions and let the labor progress. Cæsarean section is at times justifiable.

Dr. Stineharter spoke of the methods in vogue in Russia in managing these cases, and quoted the doses of morphia, etc. He held that elimination by the use of castor oil, stomach lavage and colon lavage were essential, and quoted statistics with a mortality as low as 7 to 9 per cent.

Dr. C. C. Fihe held that we should have a more definite knowledge of what constitutes eclampsia. His experience had been discouraging, both medical and surgical means having failed. A reduction in the total output of albumen was important. Fischer's solution had failed in one case and worked well in another. Acetate of soda, ten-grain doses, with plenty of water, seemed beneficial.

Dr. Martin H. Fischer believes the assumption that it is a toxemia to be corrected, that it did not always attack the same organ. The brain might be first affected, causing a different array of symptoms. Elimination is the proper treatment, and acidosis explains certain pathological changes and symptoms that follow the onset of labor in these cases. Depending on the degree of insult to the organ, the symptoms would be mild or severe.

Dr. Stanley Zinke had examined the urine in a case for the essayist, making the phenolsulphothalein test and found a normal amount excreted in the first two hours, which would lead to the conclusion that the functional activity of the kidneys was good.

The Program Committee announces Dr. W. Arbuthnot Lane, London, for November 11; Dr. Louis Hamman, Johns Hopkins, November 18; Dr. J. H. Kassell and Dr. J. Heally, December 16. Details will appear later.

October 28, 1912.

CASE REPORT NIGHT.

Paper.—"Blood Counts and Blood Examinations."—Dr. A. E. Osmond.

Case Reports.—(1) "A Cæsarean Operation; (2) Osteo-Sarcoma of Hyoid Bone."—Dr. D. D. DeNeen.

Case Report with Specimen.—"Cystic Tumor at Base of Tongue." Dr. C. T. Souther.

NOTES.

President absent. Vice President Dr. Rowe presided.

Drs. C. R. Case, Wm. C. Clark, C. Walter Manss, Charles A. Hoeffling, J. D. Spellman and Eris R. Twatchman were elected to membership.

Dr. M. L. Heidingsfeld presented a very interesting case of hereditary syphilis in whom there was an apparent initial lesion on the penis. It had all the evidences of a fresh lesion, but absolute diagnosis had not been definitely made. A second case showed marked evidences of hereditary syphilis with extensive gummatous lesions of the leg.

Dr. H. H. Hines presented a specimen of a brain containing a tumor removed post-mortem and reported the case in detail. Tumor in the posterior portion of left cerebellar lobe. This had been correctly diagnosed and a decompression operation done in March, 1912, and patient was greatly benefited. Later symptoms developed indicating that the trouble was at the sellaturcica or near hypophysis, and a second lobe operation was made on October 19, and the temporal lobe opened and region explored. Patient, however, lived only fourteen hours. (Full report will be published in the Lancet-Clinic.)

Discussed by Dr. D. T. Vail, who made the eye examination and located the tumor in the cerebellum. Dr. D. I. Wolfstein saw the case in consultation and assisted in making the diagnosis. Dr. Vail referred to the recent book by Harvey Cushing on the subject of hypophyseal tumors, and said it was the most reliable authority on this subject.

Dr. D. D. DeNeen then read the first paper of the evening—"A Comparative Study of the Appendices and Cecæ of Vertebrates, with an Addition of Small Birds' Appendices to the Literature." Dr. DeNeen's paper contained much of the comparative study of the appendix and cecæ of vertebrates, and must be read to be appreciated. The Bulletin will not try to abstract the paper, as it will be published in The Lancet-Clinic later.

Discussed by Dr. B. M. Ricketts, who complimented Dr. DeNeen on his excellent work and went over some of the anatomy of the cecal region in a number of animals.

Dr. Henry Wald Bettman—"A Definition of Nervous Dyspepsia." Dr. Bettmann's paper was brief, but carried many points of merit, which showed his ability to give this term more of a definite place in the literature. He made a plea for a better understanding of the terms already coined rather than the frequent free coinage of nomenclature in the gastro-enterological field. Full paper will appear in The Lancet-Clinic.)

Dr. Bettmann's paper was discussed by Drs. J. Henry Schroeder, B. M. Ricketts and Edwin M. Baehr.

Dr. Dunham made a motion that as Dr. A. E. Osmond had been pushed off of the Medical Section tonight, the Academy hear his paper next Monday night, October 28—case report night. Seconded and carried.

Selected Articles

TENDENCIES OF MODERN SURGERY.

Address on Surgery, delivered at the 25th annual meeting of the Medical Society of the Missouri Valley, September 5, 1912, at Council Bluffs, Ia.

Henry T. Byford, M.D., Chicago, Ill.

He who would tell of the future must look into the past where it lies mirrored. He who would understand the present must look to the future and wait until it tells him what has become of the present. It would undoubtedly be pleasant and perhaps profitable for us to follow the fashion of converting the annual address on surgery into an arithmetical sum in addition by reporting the accomplishments of the past year; but I haven't the gift of prophecy to enable me to tell what in the future will be found good, and as such should be recorded, nor what will be found bad, and as such should be forgotten. What has been done since our last meeting should be tested in the future by the work of workers rather than be rated at present by the talk of talkers. I will therefore content myself with a discussion of tendencies rather than a determination of values, and will begin by taking a look into the past, hoping, by comparing it with the present, to discover the road which the practice of surgery has been traveling and the direction it is taking, and should take in the future. To this end I will recall to your mind some of the conditions that have existed within the memory of many of us.

We know that some of our preceptors obtained their medical education in the offices and on the circuits of their preceptors and procured licenses to practice upon the basis of such education. When they had practised for a longer or shorter period they were able by attending two winter terms of six or seven months each at a medical college to obtain the degree of M.D. Up to the year 1870, when I began the study of medicine, the col-

leges delivered only one course of instruction, and in order to keep the students out of mischief for two winters, required them to sit all day and listen to all of the lectures of that course in the first year and to repeat the performance in the second year without variation. Laboratory work comprised two or three hours a week for two or three weeks of qualitative analysis and blowpipe combustion. Microscopic work consisted in looking at normal histological tissue and at a live frog's foot in the amphitheater. Physiological demonstration culminated in the opening and inspection of the abdomen of a dog in the lecture room and then killing it with chloroform.

It took the conservative professor many years to work out the problem that by attending the primary half of the course for half a day during the first winter and the senior half for half a day during the second winter the students could acquire the same amount of learning with half the sitting, and thus have time for doing something besides sitting. The quizzing was done, when it was done, during the lecture hour by the professor. The quizzing was a difficult problem for the professor, since half of the students were capable of understanding only half of what they heard, and the necessity of covering the entire field of medicine in one course of six or seven months left but little time for quizzing. They undoubtedly expected the students to pick up some crumbs of knowledge from their preceptors, and from clinics, which consisted in viewing operations from a distance and listening to didactic lectures at the bedside.

If a wise man had at that time looked forward to and planned the extended complicated and expensive system of medical education of today he would have been considered an impractical dreamer, out of touch with the times.

What I have said applies, of course, to medicine in general and largely to college work. Let us now consider some of the changes in the practice of surgery.

Fifty years ago operations were performed by preference in the patient's home in the city or country, or anywhere so not in a hospital, over which infection ever hovered like a flock of invisible vultures. Preparation of the patient, surgical nursing, after

treatment and antiseptics were in an entirely undeveloped, I might say, chaotic state. Major operations were looked forward to by the patient with terror, and the name hospital was associated in the popular mind with horrible experiences. Those who required an operation in one of the closed cavities of the body waited until death was imminent, made their will, said farewell to their friends, and seldom disappointed their heirs.

As antiseptic and aseptic methods were developed, private hospitals were fitted up in the medical centers in which the evils connected with the general hospitals were largely eliminated. Preparation for operations, antisepsis, trained nursing, personal attention of the surgeon to the after-treatment and after-operations began to tell. Surgeons began to understand the dangers, and patients began to escape them. With complete control of the patients and their surroundings and with the assistance of personally trained attendants the surgeons invaded the sacred recesses of the body with triumphant success. Under such conditions Lawson Tait accomplished marvels for the times in which he lived. Even in the general hospitals the medical staffs were placed in complete control, to the exclusion of all interference or participation of outsiders in their surgical work. Conditions were most favorable for the accomplishment of the best individual results.

Before long the operative technic of many of the major operations was perfected and the details of asepsis systematized and popularized. Post graduate schools were established by men skilled in technic and versed in asepsis, and post graduate courses were given just long enough to impart to aspiring young surgeons a dangerous amount of knowledge and a disastrous kind of confidence. General hospitals were built in the larger towns throughout the country, and postgraduate students began to do the operating in them for their communities. A postgraduate course was popularly supposed to qualify a man for a place in the front rank of surgery. As a result the major operations were no longer sent in such large numbers to men with private hospitals conducted on the closed door plan.

In large cities the general hospitals, in order to retain their patronage, had to throw open their doors to the profession and permit any physician or surgeon to perform any operation he chose to undertake, as was done in the country hospitals. The private hospitals found themselves unable to compete with the heavily endowed general hospitals under the complicated and expensive system connected with modern aseptic methods and the luxurious accommodations for the comfort of the patients and their friends, and soon had to close their doors, so that today the general bulk of major surgery is done in general hospitals. Although many specialists and older operators are working in general hospitals, a large number of men with defective training are working alongside them and are doing everything in surgery. They do the most complicated and surprising operations. And thanks to the organization by the hospital of a rigid aseptic system, their patients usually get out of the hospital alive and sometimes without serious bad results, and are effusively grateful to the operator for getting them out of the trouble they got into. And the hospitals, by serving them in the operating rooms and caring for the patients, publicly endorse their work; and the hospital authorities know not what to do.

As a result of this democratization of the practice of surgery the younger surgeons in small communities keep the work at home, and the city surgeons, seeing their occupation going, put in their spare time learning and performing the operations of the specialists. Many of the specialists, feeling the pinch, are performing the operations of general surgery. Old dogs are learning new tricks to offset the tricks of the young ones.

Competition, which nowadays is not considered the final and supreme regulator of business that it used to be, seems to be the supreme regulator of the practice of surgery. Surgeons underbid each other and patients shop for barbains. Those whose business instincts are too pronounced to be influenced by conscience compete for trade by offering or granting commissions. Physicians who have no conscience sell their cases to the highest bidder instead of seeking for the best aid obtainable. The profession has apparently joined in the procession of corrupt ex-

ploitation that characterizes this commercial age, this golden age, this age in which the golden end justifies the guilty means. In saying all this I am not blaming surgeons, either individually or collectively, for doing what they have been publicly authorized to do, nor for the presence of so many black sheep in their flock. I am merely calling attention to conditions.

The progress has been from special work done by special men in special hospitals with specially trained nurses and assistants, to general work done by general men in general hospitals with generally trained nurses and assistants. The inexperienced and poorly prepared surgeon gets the benefit of working in hospitals which not only impart dignity to his deeds, but provide best facilities and enforce the best methods for work, both in operating room service and nursing, and thus not only enable him, but teach him to do better and bigger work. On the other hand the specialist and experienced surgeons have often to dispense with things that a general hospital can not provide and that he would have if he had personal control of details and the personal training of assistants, and he therefore can not do as good work as under the old system. The tendency of this generalization has been for the people to get more of the better work of the poorer surgeon and less of the best work of the trained special surgeon. On account of the competition the patient pays less for surgery, and gets less for his money.

We must surely admit that everything connected with surgical practice is not ideal, and that conditions can not go on as they are going now. But we can not return to old conditions. That would be equivalent to saying that we are going wrong, and that there is no benefit in the new. We can not give up our well conducted hospitals with the improvements that made possible their large endowments and extended patronage. Private hospitals can not provide the same facilities and are scarcely to be reckoned with. The path of progress lies not in going back to the private hospital system, but in making the facilities for the best work as good at the large hospitals as they could be in privately conducted ones. It does not lie in the direction of restricting the operating to the few but in preparing many to do it properly.

The hospitals are doing all they can. The thing most needed is a better preparation of the men who are permitted to do the work. The present tendency of the public to turn over the new and complicated operations to the young graduate or the general practitioner who has taken a sitting course of six weeks in a postgraduate school has gone too far. The interests of the public demand that there be a development in medical education that will provide the surgical training that the surgeon now gets too largely through his practice upon his patients.

Nor is it doing the surgeon justice any more than his patients that he should be called upon to diffuse his studies and scatter his experience over a field so large that he can not hope to acquire a proficiency in the diagnosis and differentiation of all of the surgical diseases and conditions connected with them, nor be able to form a reliable opinion as to operability or desirability of operating, to say nothing of the choice of operation and the adaption of methods. What the mind directs and the hand executes daily or hourly is apt to be well done. What the mind directs and the hand executes at long intervals will fall short of excellence in proportion to the infrequency of performance and to the number of other things that occupy the mind and hand in the intervals.

In condemning such general diffusion of surgical work I do not mean to recommend a stricter adherence to the specialties along the old lines. I would rather suggest that all surgeons should be prepared for their operations in the concrete sense before they are permitted to perform them publicly and independently. This would necessitate a more specialized early education of the surgeon and an individual development upon lines for which he is best adapted, or upon which he is thrown by circumstances, or toward which he directs his work by preference. If he can attain universal surgical proficiency by living long enough and without practising text-book knowledge upon unfamiliar cases, then let him do everything in surgery, but not until then.

I can not better illustrate the growing need of selection or specializing in the study of medicine than by quoting a few lines from Wm. M. Polk's article on "Medical Education in New York." (Surgery, Gynecology and Obstetrics. August, 1912,

page 8, of Clinical Congress Supplement.) Under the heading "Teaching Along New Lines" he says:

"The scope and character of the teaching along new lines is or should be a measure of the progressive aspect of teaching. We select at random a large number of the subjects which were not recognized a few years ago; hydro- and physi-therapeutics, neurological surgery, including surgery of the peripheral nerves, diseases of the circulation including the Nauheim treatment, tuberculosis and phthisiotherapy, epilepsy, diseases of old age, tumors, immunotherapy, food poisoning, psychotherapy, medical economics, physiological therapeutics, intubation, nutrition in health and disease, contagious diseases, speech defects, autopsy technique, radiology, medical physics, neuropathology, clinical physiology, experimental therapeutics, anæsthesia, neuro-anatomy, anatomy in the living, medicolegal pathology, microphotography, life insurance examination, quarantine sanitation, sanitorium treatment of tuberculosis, infant feeding, manufacture of serums and vaccines, medical society drill, proctology, radium therapy, phototherapy, hematology, history taking, cystoscopy, cystoscopy in the female, abdominal diagnosis, antepartum obstetrics, physical diagnosis of tuberculosis, infant diagnosis, lumbar puncture, histopathology of the skin, radiography of the sinuses, bronchoscopy, esophagoscopy and gastroscopy, foreign bodies in the eye, medical gynecology, surgery of hernia, cadaver courses for all the specialties (anatomy and surgery), demonstration of instruments at factories, special courses under tropical medicine (heminthology, etc.)."

This list might be supplemented by a long list of things that have been added to the student's mental burdens along old lines.

Evidently the present undergraduate course of instruction is not all it should be and will be, although the problem is being worked out as fast as funds will permit by those who have it in charge. The subject is so interesting and pressing that I will occupy a few moments in calling to mind some of the modifications and additions to our methods of teaching and licensure that might be of benefit in preparing students for better work, and for securing better surgery in practice. Among these are a fifth year

in college for practical training, an improved system of hospital interneship, practical postgraduate courses, operative and experimental courses on living animals, operative courses on the cadaver, an assistantship in a clinic or in the private practice of a surgeon, degrees or titles differing according to the character of the instruction and licenses from the state to conform to qualifications. Examinations should be more practical than at present with reference to ascertaining what the applicant can do as well as what he can recite.

In the fifth year of the medical course the student would learn the practical and technical part of diagnosis or treatment. He would have adequate instruction in laboratory diagnosis including the methods of obtaining and examining the blood, the contents of the stomach and the different excretions and secretions in health and disease; instruction in bedside diagnosis with a short but real hospital service as assistant in hospital and dispensary clinics and to hospital internes, including case-taking, the preparation and after treatment of operations at which he had assisted in some capacity, wound dressing, hypodermoclysis, intravenous medication, etc.; instruction in practical obstetrics, including antepartum and postpartum abnormalities, the use of the methods and instruments of special practice and investigation, the estimation of blood pressure, the employment of vaccines and antitoxins and other things connected with internal medicine as well as the specialties. As no man can be expert in all kinds of work such a fifth year would, I suppose, have to be largely elective and so arranged that the future surgeons could omit some of the more complicated work connected with general medicine and could select some of the special surgical work without having to take all of it. One who wished to practice a specialty on narrow lines would find in this course such practical work in general medicine as would be necessary to enable him to understand and recognize the connection between the diseases in his specialty and general conditions. At present the specialist must qualify himself in this respect by a few years of general practice or he must make up for his deficiency by frequent consultations with

those who are qualified. But there is now no way of compelling even these makeshift compensations.

With students prepared by a fifth year of specialized study, hospital interneship could be developed so that the graduate might select the kind of hospital for his purpose, or the surgical or medical or special hospital services could be developed to give the interne more practical work than at present, including operating under the guidance of the attending surgeons. This should be made a part of the training that entitles him to procure a license to do certain work. The certificate or diploma from a hospital should mean more than it does now.

Operative work on the cadaver should, I think, be taught to the undergraduate for it would prepare him for operative work while serving an interneship or assistantship.

Whether operative and experimental work on the living animal should be undergraduate and of limited character, or whether it should be postgraduate and extensive in its scope and with special recognition I will not attempt to discuss.

The courses in postgraduate schools might be lengthened and developed to give the students a specified amount of clinical diagnosis and operative work in minor surgery and in some of the specialties, and thus be made to count in the procuring of licenses, instead of being used, as at present, to fool the public.

To what extent the fifth year, the postgraduate courses and the special and general operative courses on the cadaver and on living animals could be made to take the place of a hospital interneship, or vice versa, would be a subject for adjustment. The fifth year might be made up entirely of optional work, or be optional as a whole to those who could acquire an equivalent training in a hospital or elsewhere. The end in view would be for the college to give the young graduate a definite kind and amount of training or experience, and for the state to license him to do only what he has actually done or learned how to do. The public who trusts him and pays him has a right to this.

The conservative doctor will say that all this is too complicated to be carried out and that such restrictions are out of place in a free country. But I would remind him that the present restric-

tions that prevent men from practicing with the preparation and qualifications of fifty years ago would have seemed just as impracticable then as what I propose seems to him now. Something of the kind must come, and it should not be fifty years in coming. Fifty years ago people knew that the young medical graduate didn't know much in a practical way, and didn't allow him to hurt them; today the young men are supposed to be more modern and up-to-date than the professors who teach them. But if the public knew of the present faults of omission as well as of commission in the practice of the incipient surgeon, it would become panicky and would insist upon some such development for its own protection. The prevalence of paying commissions, of fee-splitting, of the recommendation of incompetent friends, of taking full charge of cases by those unprepared to do so, would to a great extent disappear under a proper organization of our instruction and systemization of our practice. If we can bring about such an improvement before the people demand it, and before they appoint a commission to regulate us as they regulate the railroads and the trusts, we will be doing justice to ourselves as well as our patients, rather than be giving our legislators an opportunity of doing us injustice. It is better for us to regulate ourselves, and do it right, than for our lawmakers to do it, and do it wrong.

In conclusion, let me again state that I am not trying to fix values nor suggest specific remedies, but have discussed established facts with reference to revealing tendencies and indicating the nature of needed reforms.—*The Medical Herald.*

Extracts from Home and Foreign Journals.

SURGICAL

Operation in Suppurative Meningitis.

Kostlivy, in *Archiv für klinische Chirurgie*, reports three cases of suppurative meningitis operated upon with favorable results in two cases, and observes that the surgeon should not hesitate to perform a radical operation in any case so soon as the diagnosis of an intracranial suppurative process is manifest. It is only by early operation in these cases that the conviction can be forced upon the internist that these cases belong as much to the surgeon as does suppurative peritonitis. By operation the mortality in the most severe cases of peritonitis can be reduced 50 per cent, not to mention the number of patients in whom early operation will protect against these grave complications. Perhaps the same hope will be realized in cases of suppurative meningitis.—*The Medical Brief.*

Flat Foot.

Dr. B. P. Weaver (*Jour. Ind. S. M. A.*, August 15, 1912) summarizes his view in the following conclusions: 1. Weak-foot is a condition far commoner than the average practitioner may believe, and must be considered seriously before a diagnosis of rheumatism is made. 2. All weak or pronated feet do not have depressed arches by any means, but represent rather a type in which there is a relative disproportion between weight-bearing and functional support. 3. Much can be done by the family physician to relieve and overcome this condition when once properly diagnosed, and in such treatment the irrational application of a rigid plate or brace as a life term sentence, must ultimately give way to a more thorough-going course of training in the exercise of proper functional use. 4. Proper shoeing at all times and temporary support, such as by adhesive strapping, in some cases, are potent

factors in the treatment of all cases of weak-foot which do not demand operative correction.—*International Jour. of Surg.*

Perforation of a Postoperative Peptic Ulcer of the Duodenum into the Transverse Colon.

Pinner reports a case of this type, and states that it makes the tenth on record. In all of these cases the conditions were the same, viz.: the perforation followed a retrocolic gastroenterostomy. It is evidently immaterial whether the operation was done on the anterior or posterior wall of the stomach; whether or not a Murphy button or some other resource was used. The jejunal ulcer may occur after any method. The author gives a digression on the causation of peptic ulcer in the jejunum. The general assumption is that a hyperacid gastric juice is at fault, and this is no doubt the chief factor. But not in every case do we find evidences of hyperchlorhydria, and similar ulcers may occur in the normal jejunum in which only alkaline secretions are present. In such cases we have to fall back on local injuries, embolism, arteriosclerosis, etc., as possible factors. Once these ulcers form perforation into the colon is readily intelligible. Diagnosis should not be difficult in theory. After the gastroenertsotomy, the entrance of colonic products into the stomach and vomited matter, as well as dysenteriform symptoms make the case a plain one. In practice, however, these symptoms may be quite lacking. In certain cases pains have constituted the sole symptom. The subject of prevention is bound up with that of diet, but authorities are not agreed as to what this should be. Naturally the continued presence of the original disease which led to the operation may demand constant attention. The only treatment proper is naturally a second operation.—*Medical Record.*

MEDICAL

Ignatia.

William M. Gregory, in the June number of the *Medical Summary*, considers ignata the very best tonic we have. He states that ignatia fills a place that can not be filled by

nux vomica or strychnin. Besides being a cerebrospinal stimulant, it has qualities as a nerve sedative and reconstructive which make it an exceedingly valuable remedy in all weak and excitable conditions of the nervous system. It should be used in many cases where the compound syrup of the hypophosphites is usually used, and also in many disturbed conditions of the female nervous system, where bromids and chloral are generally employed. He reports cases in which its valuable tonic properties were shown, and states that it is a remedy, or, rather, one of those peculiar vegetable remedies, that will not reveal their true curative principles to chemistry. It contains a large percentage of strychnin, but its field of action differs from that of nux vomica or strychnin. Its great value lies in the fact, which should be universally known, that it is the most powerful remedy we have to allay great nervous excitement, and at the same time give the patient permanent strength and improvement. He prefers ignatia, cinchona and dilute phosphoric acid to the hypophosphites, and he recommends it after any long and exhausting illness. It is excellent in checking the night sweats of greatly exhausted patients. He also prefers the specific tinctures of ignatia and cinchona to the pharmacopeial fluid extracts.—*The Medical Brief.*

Wine and Cider in Gout.

Motais (*Bulletin de l'Academia de Medecine*, Paris, July 2, 1912, Abst. J.A.M.A.) reports eight cases of gout in which he tested the effect of wine and cider. The wine used was the red Bordeaux wine, and his conclusions are: 1. That the use, even in moderate quantities, of the red Burgundy or Bordeaux wine, while it may not produce gout in health individuals, is likely to be injurious to those predisposed to gout or who are suffering from the disease. 2. A mild cider well made, but not too hard, prevents gout; combined with rational diet and exercise, it becomes a genuine therapeutic agent, diminishing or even reducing the frequency and intensity of the attacks. 3. The attention of therapeutists should be drawn to the action of cider in gouty affections of the eye. 4. While without doubt the pathogeny of arthritic

affections is variable, and such conditions may not apply to all cases of the disease, yet the author believes that cider should not be merely allowed to gouty patients, but should be prescribed to the majority as a habitual, perhaps exclusive beverage.—*The American Practitioner.*

Essential Hematuria.

Nelken, in the *American Journal of Urology*, believes essential or "idiopathic" hematuria to be due to some form of chronic nephritis. The cases are usually treated for stone, tuberculosis or cancer of the kidney. The lesion may, as in Albarran's case, be only as large as a millet seed. Unilateral nephritis may be the cause of the bleeding or the latter may come from one kidney in a case of bilateral nephritis. Casts and albumen are not essential in the finding of a nephritis; the presence of blood alone may be the only indication of the nephritis. A number of cases clear up without treatment. Others yield to irrigations of kidney pelvis with adrenalin chloride or nitrate of silver solutions. Decapsulation is often effectual, while some cases will yield only to nephrectomy. The operation of choice in undiagnosed bleeding from the kidney, is polar section, preferably through Broedel's line. Removal of the kidney should not be undertaken, however, before proper function tests have been made.—*The Medical Brief.*

OBSTETRICAL

Latent Eclampsia.

The expression "eclampsia without convulsions" is justly repudiated, since it is practically equivalent to "convulsions without convulsions." There is of course a well-defined condition which goes by this name and for the designation of which the term latent or marked eclampsia may be justifiable as a metaphor, but which should be entitled to a more positive appellative. In recent years latent eclampsia has come to be recognized as a particular clinical form of gestation toxicosis. It is by no means

clear that conditions so described are always one and the same thing. It is conceivable that the toxemia may be so profound that the convulsive phase is skipped, the patient passing at once into fatal coma. Eclampsia is that form of toxemia of pregnancy which developes at or near the time of labor or in the puerperium, In a large percentage of cases it is the convulsions, or the special factors which bring them about—such as high blood pressure, which constitute the real disease and are the actual cause of death. Yet when no convulsions occur it is claimed that this is due to the very intensity of the toxemia. There is evidently a paradox here, when too many convulsions produce the same results as no convulsions at all. Articles in the *Berliner klinische Wochenschrift*, September 9, by Gottschalk and Freund show that "eclampsia without convulsions" is essentially a postmortem diagnosis. The authors find subjects with all the autopsy signs of eclampsia yet with no history of the latter. There are parenchymatous degenerations in the liver and kidneys, acute hemorrhagic diathesis, and perhaps dubious finds in the placenta. Until the obscurity upon these cases can be effectually cleared up, the diagnosis of "latent eclampsia" may perhaps, as already stated, be justifiable.—*Medical Record.*

Editorial

PUBLISHER'S NOTICE—The Journal is published in monthly umbers of 48 pages at $1.00 a year, to be always paid in advance.

All bills for advertisements to be paid quarterly, after the first insertion of the quarter.

Business communications, remittances by mail, either by money order, draft, or registered letter, should be addressed to the Business manager, C. S. Briggs, M. D. corner Summer and Union Streets, Nashville, Tenn.

All communications for the Journal, books for review, exchanges, etc., should be addressed to the Editor.

THE GALLOWAY MEMORIAL HOSPITAL.

Ground has been broken for the erection of this long needed hospital, and it promises to be one of the most modern and well equipped institutions of its kind in the South. The officers of the Methodist Church are to be congratulated for starting the campaign for the necessary funds several years ago, and those of all creeds—Jews and Gentiles alike—are to be thanked for their generous financial support.

A hospital, no less than a church, should be looked upon as a house of God, and we hope this institution, when completed, will answer all the purposes for which it is built. While the Methodist Church and Vanderbilt University deserve the credit for starting this movement, we are assured that sectarianism will be put aside and the wards thrown open to people of all creeds. Let us hope that this is true, for otherwise a potentially great institution will become small and insignificant. Let us also hope that the board of directors will be made up of broad-minded men and the hospital staff of medicine and surgery elected from time to time with regard to ability rather than personal friendship. Above all else, let us trust that the twin sisters—politics and graft—may never enter the portals of this building wherein the Almighty will manifest His presence by his wonderful cures, His immortality by the faith of those preparing to join Him in the great beyond.

To Subscribers.

As we are approaching the close of the year and the beginning of a new volume of the *Nashville Journal of Medicine and Surgery* we beg to announce that we shall send statements to all subscribers who are in arrears with their subscription. In this connection we will say that acknowledgments of these statements must be made by those who receive them either with remittances or with explanation as to why payment is not made. Those who receive these statements are legally bound to pay up their arrearages. If they do not, the claims will be placed in the hands of a collecting agency, who will enforce collection by law.

We are reluctant to adopt such a course, but when subscribers absolutely ignore in every way bills for arrearages sent them, they enforce such steps on our part. We are willing to make concessions, if asked for, and we are anxious not to gain the ill will of our readers, but we must have some kind of understanding. Subscription debts differ in no wise from any other obligations and should be liquidated. We beg our readers to let us hear from them without delay. To all who pay up, we hold the premium of a handsome clinical thermometer, which will be sent to each subscriber paying his own subscription.

The break in the walls of the city reservoir recently, permitting the escape of the 50 millions of water in one section of the structure, caused a property loss of nearly a million dollars, and wonderful to relate, not a person was injured. The break, fortunately, occurred at midnight when the adjacent streets were empty. The path of the rushing torrent showed almost incredible devastation.

The Infirmary of Dr. J. T. Wilson, a prominent negro physician, of Nashville, Tenn., was destroyed by fire Sunday morning, November 9, causing a lass of $25,000. Two patients were rescued from the burning building. The fire was supposed to have been of incendiary origin.

Medical Poaching.

Our brethren of the bar have for long had a custom very closely followed by all reputable lawyers. No counsel will, unless the case is very exceptional, appear in a case where another lawyer has been consulted unless the first has relinquished all claim. Such a custom is also followed among honest doctors. However, where life and health are at stake etiquette must cometimes fall back for the time to humanity and common sense. A recent case was up before the Clerkenwell court in England where this subject was seriously considered. One doctor was called to see his patient whom he attended three days and dismissed as well. Shortly afterwards he was called by the mother who thought the patient was worse. She was reassured by the practitioner, who did not go. Subsequently she called in another doctor, who said the patient had quinsy, and told them to ask the first doctor to relieve it, sending his word that the case was urgent. The first refused to have anything further to do with the case, as another practitioner had been called and did not believe the matter to be urgent. The judge said the first doctor should have accepted the view of the second that the case was urgent, and should have continued his attendance. The second doctor thought it quite sufficient to tell the first that the case was urgent and he should then come and see. Urgency was the point in dispute and the judge decided in favor of the second doctor, though recognizing the usual custom, which practice will show must sometimes be broken. —*E. S. McK.*

British Opinion of Medical Requirements in the U. S.

The London Lancet for September, 1912, has an extensive article, "The British Medical Man Abroad." This discusses the opportunities for and the laws regulating the practice of medicine in the various countries of the world. The Lancet says: The laws regulating the practice of medicine in the various states and territories of the United States differ in a considerable extent in detail. In spirit, however, they are beginning to assume that uni-

formity which all medical reformers must desire for them. The progress of the United States is in no way better shown than in the fact that throughout its vast length and breadth there is now an attempt to secure for the people of the country adequate medical treatment based on scientific grounds. We must continue to warm the British medical man desiring to practice his profession in the United States of America that in all the more enviable centers he will find a vast number, almost a plethora, of medical men, the great proportion of whom have been thoroughly well educated and trained. He must also remember that in the more important states, generally speaking, although the remuneration may rule high, the expense of living is proportionate. Examinations are now required of all applicants in all of the states. This is very different from the way in which the British Medical Press discussed us twenty or thirty years ago.—*E. S. McK.*

Famous Twins.

It has been stated and reiterated that twins do not become famous. Dr. Kaiser, of Dresden, has made the bold statement that he has known of no famous man who has a twin brother. Dr. Simson, way back in 1862, made a similar statement in the Edinburgh Medical Journal. To contradict this are mentioned Henry and Thomas Vaughan. Those who look up the lives of these two men will not find them very strong citations. Two men named Scott, of Newcastle, England, are also cited as exceptions. They were what is known as "pigeon" twins. Each was born with a twin sister. Pigeon twins are not unusual. One yelked twins are always of the same sex. One of these at least has its development necessarily retarded and the others chances may be greatly prejudiced. There is no embryological or psychological reason why even a true twin, as an embryologist would call it, might not become famous. As for pigeon twins, they are quite independent beings, and it is only during delivery that their lives are in jeopardy. Returning to our mutton, we must reply to the question that twins very rarely attain fame, at least so far as the records teach us. Nevertheless, we must admit that the records of

births up to quite recent times have been very faulty, and a case or two of a twin attaining fame may have escaped the vigilance of the biographers. Let us hear from every one who has anything of value on the subject. Out of the four passably prominent twins mentioned here only one was a doctor. Are there any other twins who attained to such prominence?—*E. S. McK.*

Medico-Legal Collection.

The Royal College of Surgeons of England, in its museum, has started an interesting Medico-Legal collection. It contains among other things the shaft of a right femur, demonstrating a circular elevation, probably the site of a fracture which was removed from the charred remains of a body taken from the debris after the fire following the terrible siege of anarchists in White Chapel about a year ago. One of the anarchists, Joseph, was known to have a limp, and the indication of a fracture led to the identification. Another specimen of interest is the point of an umbrella four and one-half inches long, which was thrust into the pons of the medulla oblongata from the face and passed through the antrum, sphenoid and brain substance to the depth of one and one half inches. The man died in four days. The umbrella was thrust into him by his opponent in an altercation.—*E. S. McK.*

Public Prophylaxis Against Venereal Disease.

Dr. A. Ravogli, in a paper before the Cincinnati Academy of Medicine, October 7, 1912, discussed this subject as only one with his particular wisdom on this particular subject can do. He recommended that all inmates of the houses of tolerance undergo a medical examination at least once a week. The examiner should be skilled in this work, appointed by the board of health and accompanied by an officer. The sanitary condition of the house should be inspected, and but one girl should be allowed to each room. No certificates of health should be given. An inmate found diseased should be taken to the hospital. The presence of an inmate in the house should be prima facie evidence that she is not

diseased. If a woman is found in a house who has not been examined she shall be arrested and the house closed. The keeper of a house of tolerance shall report to the police the arrival or departure of inmates, where they came from, name and age.

Rules for clandestine prostitution: Girls frequenting public halls, balls and cafes must be secretly investigated by the police. If found to have no means of support and frequent male visitors, they shall be examined. On complaint of an infected male visitor the girl shall be examined, and if found diseased, sent to the hospital, where they shall be detained till there is no more danger of infection. If they wish to reform they must be treated till safe before they are allowed to go out to work.

In reference to a hospital for venereal patients: The hospital for such patients shall be guarded with secrecy. It must consist of small wards of not more than four to six beds. Means of occupation should be supplied for those able to work. No visitors should be allowed unless upon extraordinary business. He considers the Juvenile Court a most excellent institution to control the question of the prostitution of minors. He thinks that 90 per cent of all cases of venereal diseases come from sexual intercourse. The other 10 per cent are from extra genital or accidental infection. He insisted on the giving up of the idea of the certificate. If the woman was in the house that should be certificate enough that she was healthy. The inspection was not to give a sense of security but to find the foci of infection and remove them to the hospital and control and cure them. The object of reading the paper was to aid in reëstablishing the surveillance of this class of women and preventing the spread of venereal diseases.—*E. S. McK.*

The Scientific Study of the Alcoholic Problems.

In New York City in 1870 a number of physicians and medical experts formed an organization called the American Society for the Study of Alcohol and Other Narcotics. This was the first medical association in the world to take up the study of alcohol and inebriety, and determine from clinical experience, laboratory

studies, and grouping of facts, the phenomena of the spirit and drug neuroses.

The special purposes was to study this subject, above all theories and conclusions, particularly its etiological, physiological, therepeutic and medico-legal relations; also to compile and make available each studies for home, office and institutional treatment, and point out the remedies and prophylactic measures for restoration and cure.

The forty-second annual meeting of this society will be held at Washington, D. C., December 11, 1912. A large program of scientific papers from medical men, many of them distinguished foreigners, will be presented. This meeting and the subjects discussed will attract a great deal of attention, not only among medical men, but an increasing number of laymen, who have an intense personal interest in alcohol and drug taking.

Programs and further information can be had by addressing the Secretary,

Dr. T. D. Crothers,
Hartford, Conn.

Scientific Lesson from the Attempted Assassination of Colonel Roosevelt.

Arthur MacDonald, a criminal anthropologist, of Washington, and author of a Senate document entitled, "Man and Abnormal Man," suggests a plan to lessen or prevent crime and other abnormalities, especially such as the attempted assassination of Colonel Roosevelt.

Mr. MacDonald has been advocating in Congress, State Legislatures, and with mayors of large cities, this plan for many years. It is to establish laboratories or bureaus for the scientific investigation of criminals and other dangerous abnormals. He believes that every large city, and every State, and especially the Federal Government, should have such a laboratory.

> When anyone sends to the President, the Governor, or Mayor, or any prominent citizen threatening letters, or repeatedly utters threatening words, or attempts to injure such officials, or is unreasonably insistent in de-

manding to see them *personally,* such individual should be detained at least a few hours and thoroughly studied by scientific experts in criminal anthropology, psychophysics and social pathology.

A bill for such a laboratory is now pending before the Judiciary Committees of both Houses of Congress. The members of these committees are as follows:

Committee on Judiciary of the Senate—Senators Clark, of Wyoming, Chairman; Nelson, Minnesoto; Dillingham, Vermont; Sutherland, Utah; Brandegee, Connecticut; Borah, Idaho; Brown, Nebraska; Cummings, Iowa; Root, New York; Bacon, Georgia; Culbertson, Texas; Overman, North Carolina; Rayner, Maryland; Paynter, Kentucky; Chilton, West Virginia, and O'Gorman, New York.

Committee on Judiciary of the House—Representatives Clayton, of Alabama, Chairman; Henry, Texas; Webb, North Carolina; Carlin, Virginia; Rucker, Missouri; Floyd, Arkansas; Thomas, Jr., Kentucky; Graham, Illinois, Dupre, Louisiana; Littleton, New York; McCoy, New Jersey, Davis, West Virginia; McGillicudy, Maine; Sterling, Illinois; Moon, Pennsylvania; Higgins, Connecticus; Howland, Ohio; Nye, Minnesota; Norris, Nebraska, and Dodds, Michigan.

By a patient study of these dangerous, unbalanced and often illusioned persons, who may be called mattoids, their eccentricities and peculiar behavior under different conditions of life can be determined to such an extent that we shall be able to detect them in advance. At present it is almost impossible to do this, because of the little or no knowledge concerning them. This state of our ignorance is due to the want of systematic scientific and sociologic investigation.

Millions of dollars are annually expended by our Government for the scientific investigation of the antecedents, peculiarities and behavior of some little bacillus, causing the death of plants or animals, but little or nothing is given for a similar study of the larger human bacillus, which has caused this country to suffer losses beyond human calculation.

Who can estimate the mental, moral and financial cost of the United States of the assassination of Garfield, and McKinley? Shall we wait till more of our Presidents, Governors, Mayors, or other distinguished citizens lose their lives at the hands of these mattoid assassins, before we begin a serious, scientific and systematic study of such dangerous individuals?

Medico-Legal Society.

The Medico-Legal Society announces its opening fall meeting at the Waldorf-Astoria on Wednesday, October 23, 1912, at 8o'-clock p.m., for the discussion of *"Medical Expert Testimony in Homicidal Cases Where Insanity is Pleaded,"* and the merits of the Bill proposed by ex-Chief Justice Emery known as the Maine Bill.

1. Paper by Clark Bell, entitled "Medical Expert Testimony," and the merits of the Maine Bill.

2. Replies by ex-Chief Justices. Hon. Simeon E. Baldwin, of Connecticut; Hon. Orrin N. Carter, of Illinois; Hon. Charles M. Start, of Minnesota; Hon. Charles E. Frick, of Utah; Hon. William T. Spear, of Ohio; Hon. John W. Rowell, of Vermont; Hon. Eugene B. Gary, of South Carolina, and other Chief Justices of the Supreme Courts.

3. Views of Dr. R. L. Parsons, of New York; Clarence A. Lightner, Esq., of Detroit, Mich.; Charles E. George, Esq., of San Francisco; Dr. E. S. McKee, of Cincinnati, Ohio, and other prominent alienists and medico-legal jurists.

4. The American Institute of Criminal Law and Criminology; the National State and City Bar Associations; the State Medical Societies, and all cognate associations are invited to send delegates to the discussion, and their members to contribute to the discussion, and the literature will be sent on application.

5. Historical Sketch of the Supreme Court of Oregon. By Judge J. C. Moreland, of Salem, Oregon. The Supreme Court of West Virginia. By William B. Matthews, of Charleston, West Virginia.

6. The Chief Justices of the Supreme Courts of the States. By the Editor. Both professions are invited. A general attendance is desired.

CLARK BELL, Secretary.

T. D. CROTHERS, President.

MINE SURGEON (MALE.)
Bureau of Mines. November 20, 1912.

The United States Civil Service Commission announces an open competitive examination, for men only, for mine surgeon, on November 20, 1912, at the places mentioned in the list printed hereon. From the register of eligibles resulting from this examination certification will be made to fill a vacancy in this position in the Bureau of Mines at a salary ranging from $2,000 to $3,000 per annum, and vacancies as they may occur requiring similar qualifications, unless it is found to be in the interest of the service to fill any vacancy by reinstatement, transfer, or promotion.

The person appointed to this position will be expected to give instruction to the first-aid miners of the Bureau of Mines, visit them at safety cars and stations, and make sure by supervision, direction, inspection, and report that they are capable of performing their duties as instructors in first aid to miners. He will superintend the carrying out of sanitary methods in connection with cars, stations, apparatus, and the personal habits of those in mines and villages; will write miners' circulars on instruction, etc., visit mines, and observe and report on sanitary conditions in general and assist in bringing about improved sanitary conditions underground. Pathological studies will also be made as to the effect upon the human system of poisonous gases and death by shock at mine disasters. In addition he must be sufficiently active and familiar with mining to put on artificial breathing apparatus and, with the rescue force, to enter mines immediately after fires and explosions in order to take blood samples and record conditions before removal of remains from the poisonous atmosphere.

Competitors will be examined in the following subjects, which will have the relative weights indicated:

Subjects	*Weights*
1. Letter writing (the subject matter to be upon an assigned topic of medical or surgical interest)	5
2. Anatomy and physiology (regional and minute anatomy, general physiology, the physiologic functions and relations of organs	10
3. Surgery and surgical pathology (general and special surgery, surgical diagnosis, pathology, treatment, and technic	20
4. Chemistry, materia medica, and therapeutics (elementary questions in inorganic and organic chemistry, the physiologic action and therapeutic uses and doses of drugs	10
5. Bacteriology and hygiene (the technic of bacteriologic laboratory methods and the practical application of the principles of bacteriology and hygiene to prophylaxis and treatment)	15
6. General pathology and theory and practice of medicine (the etiology, pathology, symptomatology, and treatment of diseases)	20
7. Training, experience, and fitness	80
Total	100

Applicants must be graduates of a reputable medical college and must show not less than three years' postgraduate experience in medical and surgical practice about coal mines, including mine accidents, occupational diseases of minesers, etc. Special credit will be given for experience in the rendering of first aid to the injured in mine accidents; definite statement should be made as to the amount and extent of all experience claimed.

Statements as to training, experience, and fitness are accepted subject to verification.

Applicants must not have reached their fortieth birthday on the date of the examination.

This examination is open to all male citizens of the United States who meet the requirements.

Persons who meet the requirements and desire this examination should at once apply either to the United States Civil Service Commission, Washington, D. C., or to the secretary of the board of examiners at any place mentioned in the list printed hereon, for Form 1312. No application will be accepted unless properly executed and filed with the Commission at Washington. In applying for this examination the exact title, as given at the head of this announcement should be used.

As examination papers are shipped direct from the Commission to the places of examination, it is necessary that applications be received in ample time to arrange for the examination desired at the place indicated by the applicant. The Commission will therefore arrange to examine any applicant whose application is received in time to permit the shipment of the necessary papers.

Issued October 21, 1912.

Obituary

Dr. L. B. Graddy.

We are grieved to announce the death of Dr. L. B. Graddy, who died at the age of 57 years at the home of his wife's relatives in Lexington, Tenn., November 10, 1912. Dr. Graddy was an alumnus of the medical department of the University of Nashville and was for many years Professor of Diseases of the Eye and Ear in that institution. On the dissolution of the medical college with which he had for so many years been identified, he moved to Texas, where, after six months, his health failed, and he came back to Lexington, Tenn., where he died. Dr. Graddy was a skillful and successful master of his specialty and was widely known throughout the South and Middle West. His death is a great loss to the profession and is a source of great grief to his friends and patrons.

Reviews and Book Notices

The Surgical Clinics of John B. Murphy, M.D.—The Surgical Clinics of John B. Murphy, M.D., at Mercer Hospital, Chicago. Vol. I, No. 5. October. Octavo of 155 pages. Illustrated. Philadelphia and London. W. B. Saunders Co., 1912. Published Bi-Monthly. Price per year, paper, $8.00; Cloth, $12.00.

We acknowledge with thanks to the enterprising publishers the receipt of the October number of the Surgical Clinics of John B. Murphy, M.D. This number presents clinical lectures covering almost the entire field of surgery, and possesses equal interests with foregoing numbers of the series. The work done at that celebrated clinic, the methods pursued and the wonderful results obtained by the celebrated surgeon, render the presentation of these clinics in serial form of incalculable value to the practitioner who is unable to attend them *in propria persona*. In this number Dr. Murphy opens the series with a valuable lecture on Anæsthesia. Lectures follow on Nephrolithasis Cholecystitis, Gastro-Duodenal Ulcer, Appendiceal Abscess, Exophthalmic Goitre, Tumor of Spinal Cord, Retroversion of the Uterus, Ununited Fracture, Ankylosis of Left Elbow, etc. The descriptions of the operations and the comments of the lecturer are clear and to the point so that the reader clearly understands them, an art that no teacher possesses in as great degree as Dr. Murphy.

Diseases of Children.—A Practical Treatise on Diagnosis and Treatment for the Use of Students and Practitioners. By Benjamin Knox Rachford, Professor of Diseases of Children, Ohio-Miami Medical College; Department of Medicine of University of Cincinnati; Pediatrician to the Cincinnati Hospital; Good Samaritan Hospital and Jewish Hospital; Ex-President of the American Pediatric Society, and Member of the Association of American Physicians. New York and London. D. Appleton & Co. 1912.

This excellent work will meet with a hearty reception from the profession, as recent works upon pediatrics are rather rare. The author has executed a well arranged and comprehensive treatise, especially framed for the diagnosis and treatment of diseases of

children. He dwells, and very properly, on the fact that the diseases of infancy and childhood differ in their clinical manifestations from corresponding diseases in the adult, for physiological rather than pathological reasons. The author has in this work dwelt upon the physiological factors of diseases in infancy and childhood and has made practical application of these facts in the prophylaxis and treatment of these diseases. Everything has been omitted in the way of etiological discussion and pathological findings with a view to reducing the work to a thoroughly practical and working basis. We are sure our readers who desire to keep in the van of progress will find in this work a useful and thorough guide.

A Treatise On Pellagra for the General Practitioner.—By Edward Jenner Wood, S.B., M.D. Chairman of the Pellegra Commission, North Carolina Board of Health; Member of the American of Tropical Medicine; Fellow of the London Society of Tropical Medicine and Hygiene; Formerly President of the Medical Society of North Carolina, etc. With Thirty-eight Illustrations in Text. New York and London. D. Appleton & Co. 1912.

This excellent text-book and guide for the general practitioner should appeal to the profession of this part of the United States, as it has been carefully prepared by a Southern physician for the instruction of Southern physicians upon a disease essentially tropical in its habitat. The interest in this disease, which has only recently manifested itself as a scourge in the Southern states, is widespread and any work that tends to aid in the recognition of the disease and outline the management of cases when recognized should receive a hearty welcome and patronage. This book does that and presents, in well arranged form, a thorough exposition of the subject. We commend the work to the profession as a most reliable guide and handbook.

Sex Hygiene for the Male, and What to Say to the Boy.—By G. Frank Lydston, M.D., Chicago. Riverton Press.

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The Soul and Sex in Education.—By J. D. Buck, M.D. Stewart & Kidd Co., Cincinnati.

The author has been a practitioner and teacher of medicine in Cincinnati for 50 years, besides a deep student, thinker and author. In this book the author deals learnedly of love, marriage, celibacy, scientic psychology, inspiration and revelation and other questions. A good book for teachers and parents. Helpful to both adult and child.—E. S. McK.

Contents for November, 1912

ORIGINAL COMMUNICATIONS.

Insanity of Inebriety ---- 481
Syphilis in Gynecology ---- 486
Selection of Specialties ---- 488

SELECTED ARTICLES.

Tendencies of Modern Surgery ---- 498

EXTRACTS FROM HOME AND FOREIGN JOURNALS.

SURGICAL.

Operation in Suppurative Meningitis ---- 508
Flat Foot ---- 508
Perforation of a Postoperative Peptic Ulcer of the Duodenum into the Transverse Colon ---- 508

MEDICAL.

Ignatia ---- 508
Wine and Cider in Gout ---- 509
Essential Hematuria ---- 511

OBSTETRICAL.

Latent Eclampsia ---- 511

EDITORIAL ---- 513

OBITUARY ---- 524

REVIEWS AND BOOKNOTICES ---- 525

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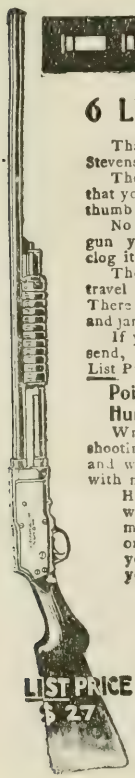

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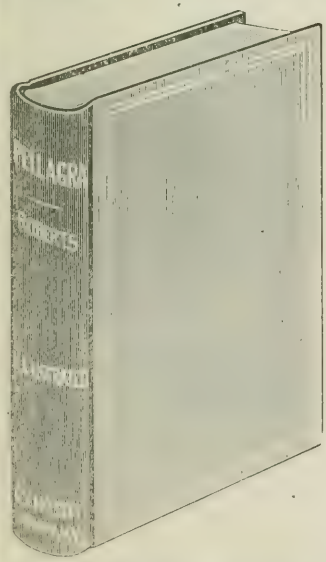

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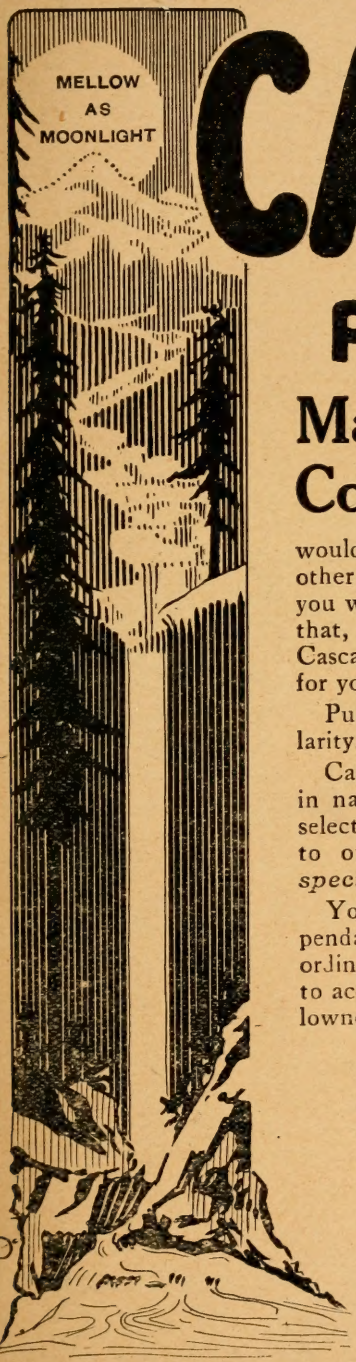

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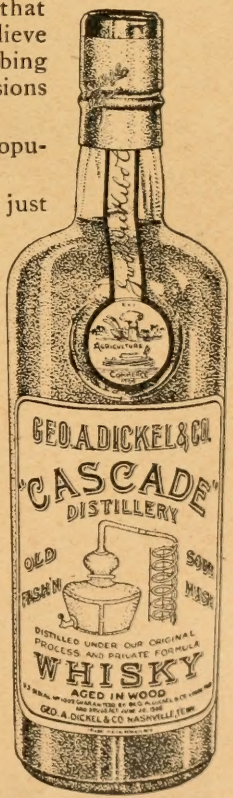

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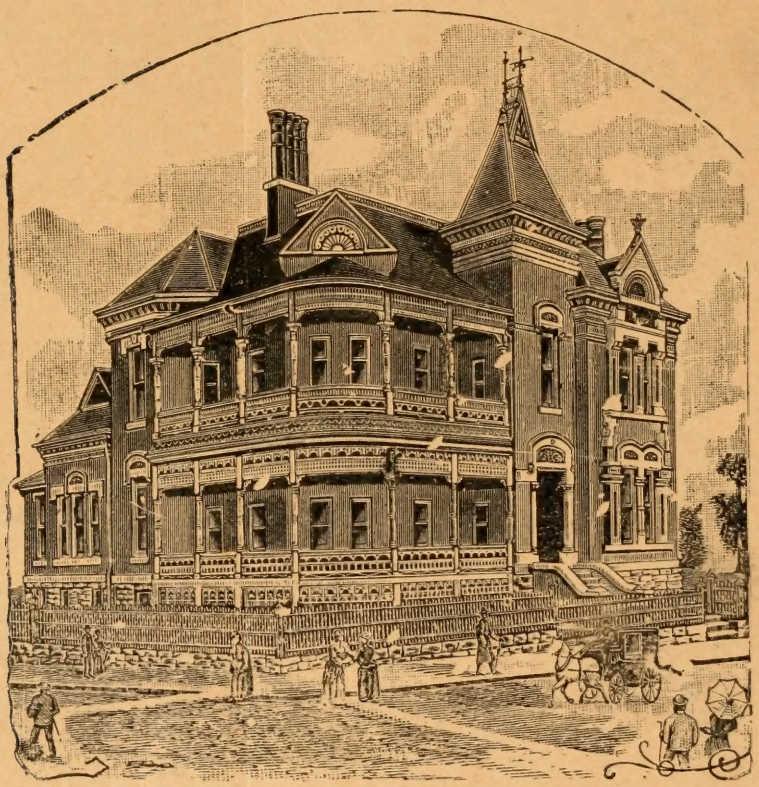

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